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CHAPTER ONE

GENERAL

Chapter 1 - General

Rule No. 560-X-1-.01. Organizational Description.

The Alabama Medicaid Agency (hereinafter called "Medicaid") administers the State Plan for Medical Assistance under Title XIX of the Social Security Act (hereinafter called "State Plan") which provides payment for authorized medical services and supplies available to categorically eligible recipients. Certain services are mandatory under Section 1902, Title XIX of the Social Security Act and other services provided are available at the option of the State of Alabama.

(1) The mandatory services include:
- (a) Physician Services
- (b) Inpatient and Outpatient Hospital Services
- (c) Rural Health Clinic Services
- (d) Laboratory and X-ray Services
- (e) Skilled Nursing Facilities Services
- (f) Early and Periodic Screening Diagnosis and Treatment (includes Dental)
- (g) Home Health Care Services and Durable Medical Equipment
- (h) Family Planning
- (i) Nurse-Midwives Services
- (j) SSA Title IV-E, Foster Care Medical Services

(2) The optional services include:
- (a) Intermediate Care Facilities Services
- (b) Prescribed Drugs
- (c) Optometric Services
- (d) Ambulance Services
- (e) Hearing Aids
- (f) Intermediate Care Facilities for Mentally Retarded and Mental Disease Services
- (g) Prosthetic Devices
- (h) Outpatient Surgical Services

(3) The following chapters contain information about the administration of the Medicaid program and the extent of the covered services available for eligible categorically needy recipients when medically prescribed.

Authority: Social Security Act, Title XIX, Section 1902(a)(10)(A); 42 C.F.R. Section 440.210; and Executive Order Numbers 38, 81 and 83. Rule effective October 1, 1982.

Rule No. 560-X-1-.02. Laws and Publications Applicable to Medicaid.

The legal authorities under which the Medicaid Program is operated are:

(1) Title XIX of the Social Security Act as amended.

(2) 42 C.F.R. Section 430, et seq.

(3) 45 C.F.R. Section 205, et seq.

(4) Alabama Executive Order No. 8, dated June 30, 1967, Executive Order No. 32, dated February 17, 1972, Executive Order No. 81, dated June 16, 1977, Executive Order No. 83, dated September 26, 1977, and Executive Order No. 38, dated March 2, 1981.

(5) Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as approved by the Federal Department of Health and Human Services.

(6) Section 1634, Public Law 92-603.

(7) Code of Alabama, 1975 Sec. 22-6-1, 27-14-11,1, 35-1-2, 36-13-8, and 36-13-9, et seq.

(8) Title VI of the Civil Rights Act of 1964, as amended.

(9) Section 504 of the Rehabilitation Act of 1973, as amended.

(10) The Age Discrimination Act of 1975.

(11) Alabama Medicaid Agency Administrative Code.

(12) Provider Notices.

(13) Clinical Laboratory Improvement Amendments of 1988 (CLIA), P.L. 100-578 (42 U.S.C. Section 263a).

Authority: All regulations cited above. Amended June 27, 1983; Amended January 13, 1993, based on OBRA '90, Section 1927. Effective date of this amendment May 13, 1993.

Rule No. 560-X-1-.03. Administration of the Alabama Medicaid Program.

The Alabama Medicaid Agency administers the state Medicaid Program as directed by the Governor. The head of the agency is the Commissioner, who serves at the pleasure of the Governor.

Authority: 42 C.F.R. Section 431.10; Executive Order No. 81, dated June 16, 1977, and Executive Order No. 83, dated September 26, 1977.

Rule No. 560-X-1-.04. Agencies Responsible for Medicaid Eligibility. (See Chapter 25 for detailed eligibility criteria.)

Applicants eligible for Medicaid services are certified to the Alabama Medicaid Agency by the following agencies:

(1) The Social Security Administration certifies aged, blind, and disabled applicants for the Federal Supplemental Security Income (SSI) Program. In Alabama, individuals eligible for SSI are eligible for Medicaid under Title XVI, Section 1902(b) of the Social Security Act and Section 1634, Public Law, 92-603.

(2) The Alabama Department of Human Resources (DHR) certifies eligibility at county DHR offices for some groups not eligible for SSI. These groups are discussed in Chapter 25.

(3) The Alabama Medicaid Agency certifies Medicaid eligibility for individuals listed in Chapter 25 through its certification district offices located throughout Alabama. Generally, there is no Medicaid coverage for individuals who are confined to a public institution unless it is a medical institution. See Chapter 25 for eligibility criteria and the descriptions of the groups covered.

(4) The Alabama Medicaid Agency restricts, and terminates eligibility in cases of fraud, abuse, and misuse.

Authority: Executive Order No. 83, dated September 26, 1977. Social Security Act 1902(a)(10)(A)(ii)(V) as amended by Section 9510 of COBRA 1985, 42 C.F.R. Section 431.10; Public Law 100-203, Sections 9108, 9116, and 9119; 42 C.F.R. Section 435.231; Public Law 100-360, Section 301. Rule effective October 1, 1982. Amended August 10, 1987. Emergency Rule effective January 8, 1988. Amended April 12, 1988 and July 12, 1988. Emergency Rule effective July 1, 1988. Amended September 9, 1988. This Emergency Rule effective January 1, 1989. Amended April 14, 1989. Effective date of this amendment January 13, 1993.

Rule No. 560-X-1-.05. Licensure and Certification of Certain Providers.

The Bureau of Licensure and Certification, Alabama Department of Public Health is responsible, through agreement with Medicaid, for licensing hospitals, skilled and intermediate care nursing facilities, and certain other health related facilities for participation in the Medicaid program.

Authority: 42 C.F.R. Section 431.610 and 431.620; Social Security Act, Title XIX, Section 1902(a)(33); Agreement, September 14, 1980, Bureau of Licensure and Certification, Department of Public Health. Rule effective October 1, 1982.

Rule No. 560-X-1-.06. Fiscal Agent.

(1) The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. The present fiscal agent contract is with EDS , Post Office Box 7600, Montgomery, Alabama. Their toll free telephone number is 1-800-688-7989.

(2) The fiscal agent will provide current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. The fiscal agent will prepare and distribute the Alabama Medicaid Agency Provider Manual to providers of Medicaid services. Such manual is for guidance of providers in filing and preparing claims.

(3) Providers with questions about claims should contact the fiscal agent. Only unsolved problems or provider dissatisfaction with the response of the fiscal agent should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, telephone number, 242-5010.

Authority: Title XIX, Social Security Act, Section 1902(a)(4); 42 C.F.R., Section 431.510. Rule effective October 1, 1982.

Rule No. 560-X-1-.07. Provider Rights and Responsibilities.

(1) In accordance with federal law, Medicaid providers shall ensure that no person will, on the grounds of race, color, creed, national origin, age or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by the Agency.

(2) Compliance with Federal Civil Rights and Rehabilitation Acts is required of a provider's participating in the Alabama Medicaid Program.

(3) Providers have freedom of choice to accept or deny Medicaid payment for medically necessary services rendered during a particular visit. This is true for new or established patients. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. The fact that Medicaid payment will not be accepted would be recorded in the patient's medical record, if one exists.

(4) Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, e.g. epidurals, spinal anesthetic, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery related pain management services.

(5) Providers, including those under contract, must be aware of participation requirements that may be imposed due to managed care systems operating in the medical community. In those areas operating under a managed care system, services offered by providers may be limited to certain eligibility groups or certain geographic locations.

Authority: Civil Rights Act of 1964, Titles VI and VII; Rehabilitation Act of 1973; Age Discrimination Act of 1975, and State Plan, Attachment 7.2-A. Rule effective October 1, 1982. Rule Amended December 19, 1992. Effective date of this amendment March 14, 1997.

Rule No. 560-X-1-.08. Recipient Rights and Responsibilities.

(1) Free choice of selecting providers of health care is a legal right of every recipient of Medicaid care and services. Freedom of choice related to an individual's opportunity to make his own decisions for his own reasons, free from the arbitrary authority of others is a recipient's right.

(2) Where prior authorization is required for Medicaid services, a recipient's choice among qualified providers shall not be restricted except by special action of the Alabama Medicaid Agency to restrict or "lock-in" a recipient to a provider of choice. (See Chapters four and five for additional information on recipient restrictions.)

(3) A recipient who believes that his free choice of provider has been denied or impaired has the right to request a fair hearing before the Alabama Medicaid Agency.

(4) When a recipient fails to advise a provider of his Medicaid eligibility and furnish other information necessary to file the claim within the time allowed by Medicaid, the provider is under no obligation to file and may elect to file with Medicaid or to bill the patient.

Authority: Social Security Act, Title XIX; 42 C.F.R. Section 431.51 & 431.54. Rule effective October 1, 1982. Effective date of this amendment August 10, 1987.

Rule No. 560-X-1-.09. Recipient Identification Number.

(1) The identification number of Medicaid eligible recipients contains thirteen (13) digits. The first three will be "000" followed by the recipient's nine (9) digit Social Security number and a number verification check digit.

(2) The Medicaid identification number will be embossed on a plastic Medicaid eligibility card issued to each individual entitled to Medicaid.

(a) Providers should question patients aged 65 or older about entitlement to Medicare.

(b) Where a Medicare claim number has not been assigned for those aged 65 or older, the recipient should be referred to the local SSA office to make application for Medicare.

(c) Claims for services covered by Medicare for persons sixty-five (65) or older may not be submitted until a Medicare number has been assigned; then claim should be filed first with Medicare with the Medicaid number listed on the Medicare claim as "other insurance".

(d) A Medicare claim number with a suffix "M" indicates there is no Medicare Part A (hospital insurance) entitlement. Hospital claims for this type number may be filed with Medicaid as regular Medicaid claims.

Authority: State Plan for Medical Assistance. Rule effective October 1, 1982. Amended May 1, 1983; June 8, 1983 and November 10, 1987. Effective date of this amendment January 13 , 1993.

Rule No. 560-X-1-.10. Provider Identification Number.

(1) All providers, except pharmacies, participating in the Alabama Medicaid Program are assigned a nine digit identification number by the Alabama Medicaid Agency fiscal agent. Pharmacies (drug providers) are assigned a provider identification number by the Medicaid Pharmaceutical Program.

(2) Providers must be licensed to practice in the state in which the service is rendered.

Authority: State Plan for Medical Assistance and the Alabama Medicaid Agency Administrative Code. Rule effective October 1, 1982. Amended May 1, 1983.

Rule No. 560-X-1-.11. Medicaid Eligibility Card.

Individuals certified eligible for Medicaid will receive a plastic Medicaid Eligibility Card through the mail with the following exceptions: certain unborns; recipients certified with a pseudo number; and recipients certified for a closed period of retroactive eligibility. These individuals will receive a one time issuance of a paper Medicaid card. Also, Medicaid recipients residing in a long term care facility will not receive a plastic Medicaid card. Each month the long term care provider will receive a computer printout listing of all Medicaid eligible recipients in the respective facility.

(1) The recipient is required to present his plastic Medicaid card and proper identification to a provider of medical care or services. The provider must verify eligibility through AVRS, MACSAS, or the Provider Inquiry Unit.

(2) Medicaid claims may be submitted for unpaid charges incurred during three (3) months prior to the month of application for an SSI recipient. Eligibility for those services must be established before claims submission.

(3) When a recipient loses or fails to receive a plastic eligibility card he/she should write or call the Alabama Medicaid Agency.

(a) Should the recipient require Medicaid services before receiving a replacement card he/she is responsible for furnishing his Medicaid number to the provider at a later time.

(b) Providers of Medicaid services shall obtain the Medicaid eligibility number directly from the recipient to verify eligibility or submit claims for services furnished the recipient. Where the Medicaid number is not available from the recipient it may be obtained from the Medicaid Agency by sending a completed inquiry form. Providers must state in their request that they have provided authorized services, supplies, or equipment to the individual whose Medicaid number is being verified.

(c) Claims submitted for services furnished a recipient must contain all thirteen digits of the recipient's Medicaid number.

(4) Providers of Medicaid services shall not submit lists of names, addresses and/or Medicaid numbers of individuals to the Alabama Medicaid Agency for verification of eligibility.

Authority: State Plan; Social Security Act, Title XIX, 42 C.F.R. Section 430, et.seq. Provider Notice 82-28, September 27, 1982. Rule effective October 1, 1982. Amended May 1, 1983; July 9, 1985; August 10, 1987, and November 10, 1987. Emergency rule effective November 16, 1987. Amended March 12, 1988. Effective date of this amendment January 13, 1993.

Rule No. 560-X-1-.12. Medicaid Eligibility Termination.

(1) When a recipient is notified by the Social Security Administration that he is no longer eligible for Supplemental Security Income, Medicaid will send him a termination notice unless he remains eligible for Medicaid under Alabama criteria. A recipient shall be notified at least 10 days before the effective date of termination from Medicaid benefits. Chapter 28 shows two types of termination notices.

(2) In all other terminations Medicaid and the Department of Human Resources issue Termination of Award Notices ending Medicaid eligibility and public assistance payments.

(3) Medicaid recipients residing in an institution may lose eligibility if they are discharged from the institution to home, or if their monthly income rises above the ceiling for Medicaid eligibility.

(4) If a Medicaid eligible person, other than a foster child, moves permanently outside the State of Alabama, he will be deleted from the Alabama Medicaid eligibility file.

(5) Foster children will lose eligibility when they cease to be foster children.

(6) Minors eligible for Early and Periodic Screening, Diagnosis and Treatment (hereinafter called EPSDT) will lose eligibility under this program at age 18.

(7) Medicaid recipients will lose eligibility when income exceeds the ceiling level established for eligibility.

Authority: State Plan, 42 C.F.R. Section 430, et seq.; Social Security Act, Title XIX. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of amendment January 13, 1993.

Rule No. 560-X-1-.13. Medicaid Payments and Recoupments for Health Services, Supplies, and Equipment.

(1) Direct payments are made for allowable charges to providers for covered medical services and supplies furnished eligible Medicaid recipients.

(a) Providers who wish to participate in the Alabama Medicaid Program must be enrolled, receive a provider number, and in most cases sign a contract with Medicaid.

(b) Licensed physicians, dentists, and osteopaths are exempt from a contract requirement, at the present time, but they do need to enroll with the fiscal agent and be assigned a provider number. Each claim filed constitutes a contract with Medicaid, embodying by reference all applicable provisions of the State Plan, this Code, and federal and state regulations.

(2) Crossover payments are partial payments to providers by Medicaid for covered Medicaid services, supplies and equipment furnished to recipients eligible for both Medicare and Medicaid.

(a) Providers of services, supplies, and equipment to eligible Medicare/Medicaid recipients must, if they accept Medicare assignment, first send their claims to Medicare and not to the Medicaid fiscal agent.

(b) If the Alabama Medicare carrier is Blue Cross and Blue Shield of Alabama, and if they accept a provider's claim they will pay him the allowable charges and forward the information to the Medicaid Fiscal agent for payment to the provider of the deductible and co-insurance charges. This is the "crossover" payment.

(3) By entering into a contract with Medicaid, the provider acknowledges that payments thereunder are subject to review, audit, adjustment and recoupment actions. In the event of any transfer, sale, assignment, merger or replacement between and among providers, Medicaid may look both to the original provider and any successor, transferee or replacement provider for recovery of any funds improperly paid. Providers should take this right of Medicaid into account and make appropriate provision therefore in their business transactions.

(4) All sites providing laboratory testing services to Medicaid recipients, either directly by provider, or through contract, must be Clinical Laboratory Improvement Amendments (CLIA) certified to provide the level of testing complexity required. Providers are responsible to assure Medicaid that all CLIA regulations are

strictly adhered to, both now and as regulations change in the future. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

(5) Laboratories which do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from the Alabama Medicaid Program.

Authority: Social Security Act, Title XIX, Section 1902(a)(32); 42 C.F.R. 447.10; Clinical Laboratory Improvement Amendments of 1988 (CLIA); P. L. 100-578 (42 U.S.C. Section 263a); and State Plan, Attachment 3.2-A. Rule effective October 1, 1982. Effective date of this amendment January 14, 1987. Effective date of this amendment May 13, 1993.

Rule No. 560-X-1-.14. Medicaid payments for Medicare/Medicaid and/or Qualified Medicare Beneficiaries (QMB) Eligible Recipients.

Medicaid pays the monthly premiums for Medicare insurance for an eligible Medicare/Medicaid and/or QMB recipient to the Social Security Administration. Medicaid also pays the applicable Medicare Part A and Part B deductibles and/or coinsurance for an eligible Medicare/Medicaid and/or QMB recipient, as specified below.

(1) Definitions

(a) "QMB" recipient is a Part A Medicare beneficiary whose verified income and resources do not exceed certain levels.

(b) "Deductible" is the dollar amount a Medicare eligible must pay for his/her own health care services.

(c) "Coinsurance" is the percentage of each bill a Medicare eligible must pay under certain conditions, in addition to the deductible amount.

(2) Part A

(a) Medicaid inpatient hospital days run concurrently with Medicare days. The Part A deductible less any applicable copay or coinsurance days are covered Medicaid services, provided the Medicaid covered days for the calendar year have not been exhausted unless the recipient is a QMB. For QMB recipients, the inpatient hospital deductible less any applicable copay, coinsurance days and lifetime reserve days are covered services for any inpatient admission.

(b) Medicaid may pay the Part A coinsurance for the twenty-first (21st) day through the hundredth (100th) day for Medicare/Medicaid and/or QMB eligible recipients who qualify under Medicare rules for skilled level of care. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the twenty-first through the hundredth day. No payment will be made by Medicaid (Title XIX) for skilled nursing care in a dual certified nursing facility for the first twenty (20) days of care for recipients qualified under Medicare rules.

(c) Medicare pays in full for Medicare-approved home health services, therefore, Medicaid has no liability for these services.

(d) Medicare pays in full for Medicare-approved hospice services, therefore, Medicaid has no liability for these services.

(e) Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate, will be paid.

(3) Part B

(a) Except as provided in this subsection, Medicaid pays the Medicare Part B deductible and coinsurance to the extent of the lesser or lower of the limit of reimbursement under Medicare rules and allowances or total reimbursement allowed by Medicaid. For ambulance services, Medicaid shall pay the Medicare Part B deductible and coinsurance for eligible QMB recipients.

(b) Medicare related claims for QMB recipients shall be reimbursed in accordance with the coverage determination made by Medicare. Medicare related claims for recipients not categorized as QMB recipients shall be paid only if the services are covered under the Medicaid program.

(c) Hospital outpatient claims are subject to Medicaid reimbursement methodology but are not subject to the outpatient limitation of three visits a calendar year.

(d) Medicare claims for rented durable medical equipment shall be considered for payment if the equipment is covered as a purchase item under the Medicaid Program. Rental payments and purchases on noncovered Medicaid items for QMB recipients shall also be considered for payment.

(4) When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/Medicaid eligibles and QMB eligibles must be sent first to the Medicare carrier. If Blue Cross and Blue Shield of Alabama is the Medicare carrier, it will forward a crossover claim for deductible and/or coinsurance to Medicaid's fiscal agent for payment. If the carrier is any other company, the claim must be filed with the Medicaid fiscal agent by the provider. The third party insurance chapter of this Code contains additional health insurance information.

(a) Providers will complete the appropriate Medicare claim forms ensuring that the recipient's thirteen (13)-digit Medicaid ID number is on the form. The completed claim shall be forwarded to an Alabama Medicare carrier for payment.

(b) If the provider's claim for service is rejected by the Medicare carrier as "Medicare noncovered service" but is a covered Medicaid service, a Medicaid claim form, completed in accordance with instructions in the Alabama Medicaid Provider Manual, with a copy of the Medicare rejection statement, should be sent to the Medicaid fiscal agent for payment. QMB-Only recipients are not entitled to Medicaid coverage for Medicare noncovered services.

(c) Providers in other states who render Medicare services to Alabama Medicare/Medicaid eligibles and QMB eligibles should file claims first with the Medicare carrier in the state where the service was performed.

Author: Lynn Sharp, Associate Director, Policy Development Unit

Statutory Authority: State Plan, Attachment 3.2-A and 3.5-A; 42CFR, Section 431.625; Social Security Act of 1988 (Public Law 100-360); Balanced Budget Act of 1997.
History: Rule effective October 1, 1982. Amended November 10, 1983; March 13, 1984; June 21, 1984; January 8, 1985; April 11, 1986; January 1, 1988; February 1, 1989; May 12, 1989; January 1, 1990; June 14, 1990; February 1, 1996; April 12, 1996; November 10, 1997. Emergency rule filed and effective October 1, 1999. Amended: Filed October 13, 1999; effective; January 12, 2000.

Rule No. 560-X-1-.15. Out-of-State Care and Services.

(1) Medical care and services provided outside the State of Alabama for Alabama Medicaid recipients are covered services if and only if such services are covered when rendered in-state and are medically necessary.

(a) Medical care and services which require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers, i.e. organ transplants, select surgical procedures. (Refer to Rule No. 560-X-1-.27 and Rule No. 560-X-6-.13 respectively).

(b) Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency as stated in Rule No. 560-X-7-.02.

Authority: State Plan; Social Security Act, Title XIX, Section 1902(a)(16) & Section 1902(a)(10)(A); 42 C.F.R. Section 431.52. Rule amended effective October 13, 1992

Rule No. 560-X-1-.16. In-State Care and Services.

(1) For each of the several categories of Medicaid covered services there may be state imposed limitations on frequency, amount, type, or kinds of services for which Medicaid will pay. Additional information concerning covered services limitation is found in the program chapters of this code.

(2) Limitations of Medicaid services and supplies may not be absolute. In individual cases of justified medical necessity they may be exceeded if prior approval is obtained from Medicaid. Chapters concerned with covered services explain how to obtain prior approval for services beyond the state's normal limit.

Authority: State Plan, Attachment 3.1-A; 42 C.F.R., Section 440.210 & 441.10; Social Security Act, Title XIX, Section 1902(a)(10)(A).

Rule No. 560-X-1-.17. Providers Claims.

(1) Providers of services and supplies shall be given claim forms by the Medicaid fiscal agent at the time of enrollment.

(2) Providers who prefer to use electronic media claims submission must sign a contract with Medicaid. Electronic media claims submission, includes, but is not

limited to, magnetic tape, diskette, or on-line computer. Approved tapes are to be obtained at the provider's expense.

(3) Instructions concerning claim forms completion and processing procedures are contained in the provider manual(s) compiled and distributed to Alabama Medicaid Providers by the fiscal agent.

(4) Time limits for Claim Submission.

(a) Medicaid will pay only clean claims submitted timely to its fiscal agent. A clean claim is a claim which can be processed for payment or denied without obtaining additional information from the provider. A timely claim is a clean claim which is received by the fiscal agent within one year of the date of service, unless a different limitation is specifically provided elsewhere in this Code.

(b) A claim which does not have sufficient information to be entered into the automated claims processing system will be returned to the provider (RTP) and will not be considered as a clean claim submitted timely to the fiscal agent.

(c) A clean claim which is not timely received by the fiscal agent will be denied as outdated, except as provided in paragraph (5) below:

(5) Exceptions to Time Limits for Claims Submission.

(a) Where a claim has been timely submitted to Medicare or other third party payor and the Medicaid claim is not timely received in payable form by the fiscal agent in accordance with paragraph (4), above, a clean claim may still be processed if received within 120 days of the notice date of the disposition by the third party payor with such date indicated on the face of the claim. If Medicare or other third party payor denies the claim, a copy of the denial notice must be attached

(b) Where a claim is for services rendered to a recipient during a time period for which retroactive eligibility has been awarded and the claim is not timely received in payable form in accordance with paragraph (4), above, a clean claim may still be processed if received by the fiscal agent within one year of the date of the award notice.

(c) Where a claim has been paid by Medicaid and is subsequently recouped, a resubmitted clean claim which is not timely received in payable form in accordance with paragraph (4), above, may still be processed if received within 120 days of the recoupment date, with such date indicated on the face of the claim. A copy of the EOP showing the recoupment must be attached.

(d) The agency may make payments at any time in accordance with a court order, or to carry out administrative review or hearing decisions taken to resolve a dispute.

(6) Time Limits for Claims Payments.

(a) Except as otherwise provided above, the Medicaid fiscal agent must process and pay all clean claims within twelve (12) months of receipt of the claim.

(b) A provider who submits a clean claim to the fiscal agent should normally receive payment or denial within ninety (90) days. If payment is not received

within this time period the provider should contact the fiscal agent for a status report of the claim.

(c) When a provider's efforts to receive payment for a claim, with the help of the fiscal agent are fruitless, the provider should write to the associate director for its program at Medicaid before the time limitation expires. Providers should contact the Third Party section at Medicaid if there are problems with TPL-related claims.

(7) Administrative Review of Claims Denied as Outdated.

(a) A provider who is denied payment on an outdated claim may request an administrative review of the claim. A written request for an administrative review should be addressed to the appropriate program area and must be received by Medicaid within sixty (60) days of the date the claim becomes outdated, which is the time limit provided in paragraph (4)(a), except that a claim falling within one of the exceptions in paragraphs (5)(a), (b) or (c), above, becomes outdated at the expiration of the 120-day or one-year period, whichever is applicable.

(b) A provider is not entitled to a fair hearing on an outdated claim until after an administrative review of the claim. A hearing request received prior to or in lieu of a request for an administrative review will be treated in all respects as a request for an administrative review.

(c) It is the responsibility of the provider, when submitting outdated claims for an administrative review, to furnish adequate documentation of its good faith attempts to obtain payment of the claim, including copies of relevant EOPs and correspondence with the fiscal agent and Medicaid. The provider must also include an error-free claim to furnish the fiscal agent in cases where the decision is favorable.

(d) Where a provider has timely requested an administrative review, research of the claim history reveals that the claim was originally filed before it became outdated under paragraph (7)(a), and the provider has established that it made a good faith effort to file a clean claim, Medicaid shall have the authority to instruct the fiscal agent to waive the filing limitation and process the claim

(e) The provider will be notified in writing of the review decision. A provider who has timely requested an administrative review and received an adverse decision may request a fair hearing in accordance with Chapter 3 of this Administrative Code. Such request must be in writing and received by Medicaid within 60 days of the date of the administrative review denial letter. A provider is not entitled to further administrative review or a fair hearing on an outdated claim which is processed under this rule and which is denied due to a provider error on the claim.

(f) If all administrative remedies have been exhausted and the claim is denied, THE PROVIDER CANNOT COLLECT FROM EITHER THE RECIPIENT (PATIENT) OR HIS/HER SPONSOR OR FAMILY.

Author: Bill Butler, General Counsel, Office of General Counsel
Statutory Authority: 42 C.F.R. Section 447.45; Social Security Act, Section 1902(a)(27).
History: Rule effective October 1, 1982. Amended April 11, 1985; January 1, 1986; ER April 27, 1987; August 10, 1987; March 12, 1988; May 12, 1989, December 14, 1990 and January 13, 1993. **Amended:** Filed August 21, 2002, effective November 15, 2002.

Rule No. 560-X-1-.18. Provider/Recipient Signature on Claim Forms.

(1) Provider Signatures.

(a) Medical Claims: Individual practitioners may sign a medical claims submission agreement with Medicaid for the submission of paper claims in lieu of signing individual claims forms. By signing the claim agreement, the provider agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients; to furnish Medicaid, the Secretary of HHS, or the State Medicaid fraud control unit such information and any information regarding payments claimed by the provider for furnishing services, upon request; to certify that the information on the claim is true, accurate, and complete, and that the claim is unpaid; and that the provider understands that payment of the claim will be from federal and state funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws. If an agreement is not signed, the individual practitioner must personally sign the claim form in the appropriate area or place his/her initials next to a typewritten or stamped signature. An individual practitioner's name or initials may be written by another person who has power of attorney from the practitioner to do so.

(b) Institutional Claims: A representative of the institution must sign the UB-82 claim form in the appropriate area or place his/her initials next to a typewritten or stamped signature certifying that the statements on the reverse apply to the bill and are made a part thereof. Nursing facilities and home health agencies filing on a turnaround document must have representative sign the certification block on the statistical page.

(c) Pharmacy Claims: Either the pharmacist's signature, the printed name of the pharmacist or the statement "signature on file" must be placed on the drug claim form as certification that the provider agrees to the statements referenced in (1)(a).

(2) Recipient Signature.

(a) While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, e.g., release forms or sign-in sheets, as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below.

1. The recipient signature is not required when there is no personal recipient/provider contact as is usually the case for laboratory or radiology.

2. Illiterate recipients may make their mark, for example, "X" witnessed by someone with their dated signature after the phrase "witnessed by."

3. Interested parties may sign claim forms for recipients who are not competent to sign because of age, mental, or physical impairment.

4. Home Health recipient signatures are obtained on the Home Health certification form which acknowledges services are medically necessary and approved for payment.

5. The recipient signature is not required on the provider multiple listings (Turnaround Document) of nursing facility patients, for claim processing by the fiscal agent. Certification by the provider is indicated by their

signature on the statistical page attached to the Turnaround Document when submitted to the fiscal agent.

6. The recipient signature is not required when a home visit is made by a physician. The physician must provider documentation in the medical record that the services were rendered.

7. For services rendered in a licensed facility setting, other than the provider's office, the recipient's signature on file in the facility's record is acceptable.

(b) When payment has been made on claims for which the recipient signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recovered.

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32. Rule effective October 1, 1982. Amended May 15, 1983, October 7, 1983, and January 1, 1984. Effective date of this amendment October 12, 1991.

Rule No. 560-X-1-.19. Sales Tax on Medicaid Paid Items.

(1) State and municipal gross sales taxes within Alabama are not to be included in charges for Medicaid covered services, medical supplies and equipment.

(2) Alabama law exempts from any state gross sales taxes all medicines prescribed by physicians when the prescription is filled by a licensed pharmacist, or sold to the patient by the physician, for human consumption or intake.

Authority: Act 81-663 of the Alabama Legislature.

Rule 560-X-1-.20. Consent for Health Services for Certain Minors and Others.

Consent for health services for certain minors, and others will be governed by Code of Alabama, 1975, Title 22, Chapter 8.

Authority: Code of Alabama, 1975, Section 22-8.

Rule No. 560-X-1-.21. Provider Medicaid Records Inspection/Audit.

(1) Alabama Medicaid providers shall keep detailed records in Alabama, except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.

(2) Providers shall make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, Alabama Medicaid Agency and other agencies of the State of Alabama. Provider records and operating facilities shall be made available for inspection during normal business hours.

(3) All providers shall, upon either verbal or written request from any agencies listed above, furnish free of charge a copy of any requested record. If the provider has no copies, the provider must allow the person requesting the copy to check out the original for copying. The provider may require that a receipt be given for any original record removed from his premises.

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32. Rule effective October 1, 1982. Amended May 15, 1983 & October 7, 1983. Effective date of this amendment January 1, 1984.

Rule No. 560-X-1-.22. Authorship of Regulations.

The author of all rules and regulations is the Commissioner of Medicaid, the Head of the Agency.

Authority: Executive Order No. 38, dated March 2, 1981 and Executive Order No. 83, dated September 26, 1977.

Rule No. 560-X-1-.23. Payments.

(1) All payments shall be subject to the availability of appropriated funds for the Alabama Medicaid Program.

(2) Notwithstanding anything in this Code to the contrary, in the event of proration of State Funds available to the Alabama Medicaid program, payment for Medicaid benefits shall be made in accordance with provisions of the Alabama State Plan for Medical Assistance.

Authority: State Plan; Code of Alabama, 1975, Section 41-4-90.

Rule No. 560-X-1-.24. Limitations on Providers.

(1) The Alabama Medicaid Agency will normally enroll providers of covered services and issue provider contracts to new provider applicants who meet the requirements of the Code of Federal Regulations, the licensure and/or certification requirements of the State of Alabama, and the Administrative Code and operating procedures of the Alabama Medicaid Agency.

(2) Providers who have been convicted of fraud will not be considered for contract with the Medicaid Agency.

(3) The Alabama Medicaid Agency may terminate an existing contract of a provider when the Agency determines that during the last fiscal year the provider has provided services to Medicaid-only recipients not exceeding five claims and/or $100.00.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 431.51, Section 440.230, Section 440.240, Section 442.12(d)(1), Section 447.204, Section 442.10, et seq., Section 431.107, Part 455, Subpart C, and Part 405. Rule effective May 9, 1984. Amended March 11, 1985. Emergency rule effective April 16, 1987. Effective date of this amendment July 10, 1987.

Rule No. 560-X-1-.25. Copayment (Cost-Sharing).

(1) Medicaid recipients are required to pay the designated copayment amount for the following services (including Medicare crossovers):

(a) Physician office visits (including optometric)
(b) Inpatient hospital admissions
(c) Outpatient hospital visits
(d) Rural health clinic visits
(e) Durable Medical Equipment
(f) Medical Supplies
(g) Pharmaceutical

(2) The copayment amount does not apply to services provided for the following:

(a) Pregnancy
(b) Recipients under 18 years of age
(c) Family planning

(3) In addition to the exemptions in (2) above, each service has other specific exemptions. Please refer to the appropriate chapter for a complete list of the exemptions.

(4) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Authority: State Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 447.50, Section 447.55, Section 447.15. Rule effective June 8, 1985.

Rule No. 560-X-1-.26. Ancillary Services Associated with Noncovered Benefits.

(1) When a medical benefit is a noncovered service under the Alabama Medicaid Program, all ancillary charges related to delivery of that benefit are also considered noncovered.

Authority: State Plan, Title XIX of the Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective February 20, 1986.

Rule No. 560-X-01-.27 Organ Transplants

Alabama Medicaid will cover organ transplants under the following terms and conditions. These terms will apply to all procedures except cornea transplants.

(1) Transplants must be performed in the state of Alabama if medically available and appropriate for particular patient and transplant type with the exception of (8)(d) below.

(2) All transplant candidates must be from referrals by EPSDT or the primary physician.

(3) All transplant evaluations must be conducted by the Medicaid primary contractor. If the primary contractor is unable to perform the transplant, a referral to another facility may be made. The primary contractor will be responsible for coordination and reimbursement of referrals.

(4) The following transplants are covered for recipients of any age:
- (a) bone marrow,
- (b) kidney,
- (c) heart,
- (d) lung,
- (e) heart/lung,
- (f) liver,
- (g) pancreas,
- (h) pancreas/kidney,
- (i) liver/small bowel,
- (j) small bowel

(5) For EPSDT referrals, other transplants may be considered for approval if medically necessary, therapeutically effective, and nonexperimental.

(6) All transplants must be prior approved by Medicaid. The primary contractor will forward a recommendation packet to Medicaid following evaluation of the recipient. Medicaid will issue notice to the recipient of approval or denial.

(7) Recipients who are denied Medicaid coverage for transplants will be offered the opportunity for a fair hearing under the provisions of Chapter Three of this code.

(8) Reimbursement
- (a) Reimbursement will be a global payment established by Medicaid. The global payment will include the following:
  1. pre-transplant evaluation,
  2. organ procurement,
  3. hospital room, board, and ancillary services,
  4. out of hospital ancillary services,
  5. post-operative care,

6. pharmacy and laboratory services, and
7. all professional fees.

(b) Services provided after discharge will be reimbursed on a fee for service basis.

(c) Reimbursement provisions apply to transplants performed both instate and out-of-state. The global payment represents full payment for all services associated with the transplant. Recipients may not be billed for the difference between the submitted amount and the global payment.

(d) Third Party Payors: Medicaid is a payor of last resort. When a primary payor other than Medicaid has obligated to cover the transplant Medicaid may, at its discretion, approve that payor's site preference for the transplant.

(9) Cornea transplants are covered for defects (as diagnosed by ophthalmologists) which are correctable by transplant.

(10) Cornea transplants do not require prior approval.

(11) Reimbursement for cornea transplants will be normal Medicaid pricing methodology.

(12) Services associated with cornea transplants will be counted in a recipient's regular Medicaid benefit limits.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: Title XIX, Social Security Act; 42 CFR, Section 405.310(k), Section 440.10, Section 440.50, et seq; State Plan, Attachment 3.1.E and Attachment 4.19B, Section18.
History: Rule effective June 10, 1987. Amended July 17, 1991; October 12, 1991; May 13, 1996; January 12, 1998; and January 11, 1999. Amended: Filed October 20, 1999; effective January 12, 2000. Amended: Filed May 22, 2000; effective August 10, 2000. Amended: Emergency Rule filed January 19, 2000; effective February 1, 2001. Amended: Filed January 19, 2001; effective April 18, 2001. Amended: Filed July 20, 2001, effective October 16, 2001.

Rule No. 560-X-1-.28 Early and Periodic Screening, Diagnosis and Treatment.

(1) Early and Periodic Screening, Diagnosis, and Treatment will be available for Medicaid-eligible recipients under the age of 21 years old. This coverage will be provided for medically necessary health care, diagnosis, treatment and/or other measures described in Section 1905(a) of the Social Security Act and more specifically in Chapter 11 of the Administrative Code.

(2) The services must be necessary to correct or ameliorate a defect, physical or mental illness, or other conditions discovered during or as a result of an EPSDT screen, whether or not the services are covered or exceed benefit limits as stated in the

State Plan. Misspent funds identified as a result of retrospective review will be recouped in accordance with the procedures in Chapter 4 of the Administrative Code.

Authority: State Plan, Attachment 3.1-A, Title IX, Social Security Act Section 1905, 42 CFR 440,441. OBRA-89 Section 6403. Rule effective December 14, 1990.

Rule No. 560-X-1-.29 Managed Care.

Medicaid services offered by Managed Care Plans will be available for Medicaid recipients residing in areas of the State targeted for managed care implementation. The Managed Care Plan must cover all services as specified in the contract between the Agency and the Plan and shall not be less in amount, duration and scope, than those available to other Alabama Medicaid eligibles, as specified in the Alabama State Plan for medical assistance.

If an enrollee utilized a Plan's non-contract provider for in-plan services, other than emergency services, family planning services, and services provided by an FQHC, the Plan shall not be liable for the cost of such utilization unless the Plan referred the enrollee to the non-contract provider or authorized the out of Plan utilization. Payment by the referring Plan for properly documented claims shall not exceed the maximum fee-for-service rates applicable for that provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the Plan and the Plan's non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by the Plan's non-contract providers.

Authority: 42 C.F.R. Section 447.15. Effective date of this amendment: August 12, 1994.